Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 12/12/11
Amount 155.00

#10091

I. IDENTIFICATION

Name St claire Medical Center

Address 222 Medical Circle

City/County/Zip Morehead KY 40351

Telephone number (606) 7836650

Administrator Karen Holifield 606 7836654
kaholifield@st-claire.org

Date facility operation began at current address 10/25/1996

Date facility began operation under current owner 10/25/1996

II. TYPE BEDS

	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	10	
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State
County
City
(Private)

Profit
(Nonprofit)

Individual
Partnership
(Corporation)

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Sisters of Notre Dame at Covington KY.
A congregation of the Catholic Church.

(OVER)

If facility owned or leased by a corporation, complete the following:

Name of corporation St Claire Medical Center

Address of corporation 222 Medical Circle, Morehead KY 40351

President or Chairman Mark Nerf CEO of Hospital
Robert G. Stevens President of Board

Vice President None.

Secretary John Northcutt

Treasurer John Northcutt

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Management Company

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

[signature] NHA — Administrater — 11/29/11

Signature of authorized representative — Title — Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)